

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

## CERTIFICATE OF DEATH

★ Reg. Dist. No. 111

1. PLACE OF DEATH:  
County... Horseshoe  
City or town... East New Market  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State... County...  
City or town...  
(If outside city or town limits, write RURAL and give nearest town)  
Street No...  
(If rural, give LOCATION)  
2.(a) If veteran, name war...

3. (a) FULL NAME  
Abbie A. Brown

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Nov 5 1879 8. (c) If alive, give age... years

8. AGE: Years 66 Months 10 Days... If less than one day... hrs. ... min.

9. Birthplace... Ind.  
(Town, county, and state)

10. Usual occupation... House work

11. Industry or business

12. Name... Johnathan C. Guderson13. Birthplace... Ohio14. Maiden name... Elizabeth Shaw15. Birthplace... Ohio16. Informant... Rev W. R. BrownAddress... East New Market17. Burial Date thereof... Oct 3 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... CemeteryLocation... East New Market18. Funeral director... F. B. WilliamsonAddress... East New Market19. Oct. 2 19 45 Elizabeth Smith

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 19 45 at 9:30 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 10 19 45 to Oct 2 19 45and that I last saw him alive on Sept. 30 19 45Immediate cause of death Infarction of DURATIONmyocardium ofpossibly arteriosclerosis.Due to arteriosclerosisDue to arteriosclerosisOther conditions... Paralyzed

(Include pregnancy within 3 months of death)

Major findings of operations... Arteriosclerosis

Date of op. ...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Elizabeth SmithAddress... East New Market

M. D. or other

Date signed 10-2-45

UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED

UNITED STATES DEPARTMENT OF JUSTICE

UNITED STATES DEPARTMENT OF JUSTICE

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OCT 24 1945

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore Ba

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

## 1. PLACE OF DEATH:

County... DorchesterCity or town... Cambridge  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? entire life

Hospital, institution, or street address where death occurred:

How long in hospital or institution? .....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... md. County... WorCity or town... Cambridge  
(If outside city or town limits, write RURAL and give nearest town)Street No. Tranter St.  
(If rural, give LOCATION)2(a) If veteran, name war none

## 3. (a) FULL NAME

Mary W. Byrne

## 3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Feb 15 - 1863

6. (c) If alive, give age..... years

8. AGE: Years Months Days If less than one day

82 0 2 .....hrs. ....min.9. Birthplace... Cambridge

(Town, county, and state)

10. Usual occupation... Retired School Teacher

11. Industry or business

12. Name... Wm. Wilson Byrne13. Birthplace... Wor Co.14. Maiden name... Clara Byrne15. Birthplace... Wor Co.16. Informant... Mrs. S. L. ByrneAddress... Cambridge, Md.17. Burial Date thereof 10-19-45  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... CambridgeLocation... Cambridge, Md.18. Funeral director... Kenneth R. ThomasAddress... Cambridge, Md.19. 10-19-45 John M. [unclear]  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... Oct 17 19 45, at 8 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 20 19 44 to Oct 17 19 45and that I last saw her alive on Oct. 10 19 45

Immediate cause of death

Pericardial Aneurysm

DURATION

1 year +Due to arteriosclerosis Generalizedand Cerebral

Due to.....

Other conditions Senility

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE... Eldridge H. [unclear]Address... Cambridge, Md.

M. D. or other

Date signed 10-19-45

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OCT 24 1945

BUREAU V N

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

10043

## 1. PLACE OF DEATH:

County..... Dorchester  
 City or town..... Seaford Del R.D.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

41 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... MD County..... Dorchester

City or town..... Seaford Del R.D.  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Frank Cannon

## 3. (b) Social Security Number

221-05-5343

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife.....

Glatis Cannon

7. Birth date of

deceased (mo., day, yr.)

6.(c) If alive, give age.....

52 yearsNov 17 - 1903

8. AGE:

Years

Months

Days

If less than one day

411029

hrs.

min.

9. Birthplace.....

Dorchester Co. MD  
(Town, county, and state)

10. Usual occupation.....

Painter

11. Industry or business

FATHER

12. Name.....

Jerry Cannon

13. Birthplace

MD  
Pearl Fisher

14. Maiden name.....

MOTHER

15. Birthplace

MD  
Glatis Cannon

16. Informant.....

Address

Seaford, Del. R.D.

17.

(Burial, cremation or removal of which?)

Date thereof.....

10 - 18 - 1945  
(month) (day) (year)

Cemetery or crematory.....

Galestown

Location.....

Galestown MD  
Gravenor Bros

18. Funeral director.....

Address

Shapton MD

19.

(Date rec'd by registrar)

Oct 17 - 45Joe Hastings

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Oct 15 1945 at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 15 1945 to Oct 15 1945and that I last saw him alive on Oct 15 1945

Immediate cause of death.....

Pulmonary Tuberculosis

DURATION

7 years

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

H.S. Kuhlman

M. D.

Address..... Shapton MD Date signed 10/19/45

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NOV 5 1945  
BUREAU V.R.



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

## CERTIFICATE OF DEATH

10044

Reg. Dist. No. 116

1. PLACE OF DEATH Dorchester Co  
 County.....  
 City or town..... Cambridge Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 200 days  
 Hospital, institution, or street address where death occurred.....  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State..... County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2(a) If veteran, name war.....

3. (a) FULL NAME

Martha Carr

3. (b) Social Security Number

4. Sex female 5. Color or race Col 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Joseph Carr  
Dec 18 1890 6. (c) If alive, give age 64 years  
 7. Birth date of deceased (mo., day, yr.) 1890  
 8. AGE: Years 55 Months Days If less than one day  
 hrs. min.

9. Birthplace Andrew Md  
 (Town, county, and state)

10. Usual occupation house work

11. Industry or business

12. Name Glenn Emmell

13. Birthplace Andrew Md

14. Maiden name Hannah Emmell

15. Birthplace Andrew Md

16. Informant George Carr

Address Cambridge Md

17. Burial Date thereof Nov 4 1945  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cemetery

Location Cambridge Md

18. Funeral director Sevier H. Bayman

Address Cambridge Md

19. 11-14-45 45 John H. Bayman  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31 1945, at 8:00 p M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 20 1945 to Oct 31 1945  
 and that I last saw him alive on Oct 28 1945

Immediate cause of death Cerebral hemorrhage

Due to Cardio-vascular disease

Due to.....

Other conditions Chronic cholecystitis

(Include pregnancy within 3 months of death)

Major findings of operations.....

Antopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Dr. E. Bayman Md

Address 3100 N. Charles St. Baltimore Md M. D. or other  
 Date signed 11-4-45

DURATION

4 days

not from

2 yrs

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NOV 8 1945  
BUREAU V.E.



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10045



Reg. Dist. No. 116

<b>1. PLACE OF DEATH:</b> County <u>Dorchester</u> City or town <u>Cambridge</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>several years</u> Hospital, institution, or street address where death occurred: <u>Wagh Chapel - High St. Cambridge.</u> How long in hospital or institution? <u>X</u>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Dorchester</u> City or town <u>Cambridge</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>41 Douglass</u> (If rural, give LOCATION) 2.(a) If veteran, name war.....											
<b>3. (a) FULL NAME</b> <u>Jessie Cornish</u>				<b>3. (b) Social Security Number</b>											
<b>4. Sex</b> <u>Female</u>		<b>5. Color or race</b> <u>colored</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>Married</u>		<b>MEDICAL CERTIFICATION</b>									
<b>6. (b) Name of husband or wife</b> <u>Charles E. Cornish</u> <b>7. Birth date of deceased (mo., day, yr.)</b> <u>October 17, 1891</u> <b>8. AGE:</b> <table border="1"> <tr> <td>Years</td> <td>Months</td> <td>Days</td> <td>If less than one day</td> </tr> <tr> <td><u>53</u></td> <td><u>11</u></td> <td><u>27</u></td> <td><u>X</u> hrs. .... min.</td> </tr> </table>				Years	Months	Days	If less than one day	<u>53</u>	<u>11</u>	<u>27</u>	<u>X</u> hrs. .... min.	<b>20. DATE OF DEATH</b> <u>October 14</u> 19 <u>45</u> , at <u>11-35A</u> M <b>21. I CERTIFY</b> that death occurred on the date above stated; that I attended deceased from <u>X</u> .....19....., to..... <u>X</u> .....19..... and that I last saw h..... <u>X</u> .....alive on..... <u>X</u> .....19..... Immediate cause of death..... <u>Myocarditis (Chronic)</u> Due to..... <u>X</u> ..... Due to..... <u>X</u> ..... Other conditions <u>Diabetes Mellitus</u> (Include pregnancy within 8 months of death) Major findings of operations..... <u>X</u> ..... Date of op..... Autopsy results..... <u>X</u> ..... PHYSICIAN: Please underline the cause to which death should be charged statistically.			
Years	Months	Days	If less than one day												
<u>53</u>	<u>11</u>	<u>27</u>	<u>X</u> hrs. .... min.												
<b>9. Birthplace</b> <u>Maryland</u> (Town, county, and state) <b>10. Usual occupation</b> <u>Housewife</u> <b>11. Industry or business</b> <u>X</u>				<b>DURATION</b> <u>1 1/2 yr.</u> <u>2 yr.</u>											
<b>FATHER</b> <b>12. Name</b> <u>K. Handy</u> <b>13. Birthplace</b> <u>Maryland</u>		<b>MOTHER</b> <b>14. Maiden name</b> <u>Della Blake</u> <b>15. Birthplace</b> <u>Maryland</u>		<b>22. VIOLENCE:</b> If death was due to external causes, fill in the following: Accident, suicide, or homicide..... <u>X</u> ..... Date of..... <u>X</u> ..... Where did injury occur?..... <u>X</u> ..... (City or town) (County) (State) Injured at home, farm, industry, public place (where?)..... <u>X</u> ..... Means of injury..... <u>X</u> ..... Injured at work? <u>X</u>											
<b>16. Informant</b> <u>Charles E. Cornish</u> Address <u>41 Douglass St. Cambridge, Md.</u>				<b>23. SIGNATURE</b> <u>Jo K. Shriver, Dep Med Exam</u> M. D. or other Address <u>Cambridge, Md.</u> Date signed <u>Oct. 14/45</u>											
<b>17. Burial</b> Date thereof <u>Oct 21, 1945</u> (Burial, cremation, or removal. Which?) (month) (day) (year) Cemetery or crematory <u>Wagh Cemetery</u> Location <u>Cambridge Md</u> <b>16. Funeral director</b> <u>H. M. McElain &amp; Son</u> Address <u>Cambridge Md</u> <b>19. 10-22</b> 19 <u>45</u> <u>John M. McElain, Jr.</u> (Date rec'd by registrar) Registrar				<b>22. VIOLENCE:</b> If death was due to external causes, fill in the following: Accident, suicide, or homicide..... <u>X</u> ..... Date of..... <u>X</u> ..... Where did injury occur?..... <u>X</u> ..... (City or town) (County) (State) Injured at home, farm, industry, public place (where?)..... <u>X</u> ..... Means of injury..... <u>X</u> ..... Injured at work? <u>X</u>											

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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OCT 24 1945  
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 928

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH: *Worcester*  
 County.....  
 City or town.....*Cambridge*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....*1 week*  
 Hospital, institution, or street address where death occurred:  
 .....  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State.....*MD* County.....*Anne Arundel*  
 City or town.....*Annapolis*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....*305 N. Linden Ave.*  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME  
*Alonza Lee Creighton*

3. (b) Social Security Number  
*214-05-2531*

4. Sex.....*M*  
 5. Color or race.....*white*  
 6. (a) Single, married, widowed, or divorced.....*married*

6. (b) Name of husband or wife.....*Beatrice Mary Taylor*

7. Birth date of deceased (mo., day, yr.).....*August 8, 1902*  
 6. (c) If alive, give age..... years

8. AGE: Years.....*43* Months.....*2* Days.....*18*  
 If less than one day..... hrs. .... min.

9. Birthplace.....*Fishing Creek, Md.*  
 (Town, county, and state)

10. Usual occupation.....*Retired Seaman*

11. Industry or business.....*Pusser Claiborne Annapolis Md*

12. Name.....*John Creighton*

13. Birthplace.....*Wor Co.*

14. Maiden name.....*Cora Adams*

15. Birthplace.....*Wor Co.*

18. Informant.....*Mrs. A. Lee Creighton*

Address.....*305 N. Linden Ave. Annapolis Md*

17. Burial.....*Burial* Date thereof.....*Oct 28 1945*  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematorium.....*Cedar Bluff*

Location.....*Annapolis, Md*

18. Funeral director.....*James H. Taylor - Annapolis, Md*

Address.....*Cambridge, Md*

19. *Oct. 27-1945* Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....*Oct 26* 1945 at *1240* P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
*10/20* 1945 to *10/26* 1945

and that I last saw him.....*in* alive on *10/26* 1945

Immediate cause of death.....*myocardial infarction with complete*

*suppression of heart*

Due to.....*Myocardial Insufficiency, Dilatation*

+ *overcompensation*

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....*no operation*

Date of op.....

Autopsy results.....*none*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....*none* Date of.....

Where did injury occur?.....  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....*—* Injured at work?.....*—*

23. SIGNATURE.....*Guy Stuck*

Address.....*Cambridge, Md* M. D. or other  
 Date signed.....*10/26-1945*

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OCT 30 1945  
BUREAU A.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-a

## CERTIFICATE OF DEATH

Reg. Dist. No. 10047-15

## 1. PLACE OF DEATH:

County... 10 minutes  
 City or town... Fishing Creek  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
Home  
 How long in hospital or institution? no.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Maryland County... Dachman  
 City or town... Fishing Creek, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. near Methodist Church  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war no.

## 3. (a) FULL NAME

Laura Creighton

## 3. (b) Social Security Number

no.

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced married

8.(b) Name of husband or wife Levin H. Creighton  
 8.(c) If alive, give age 87 years

7. Birth date of deceased (mo., day, yr.) Feb. 5-1864

8. AGE: Years 81 Months 8 Days 2 If less than one day  
 hrs. min.

9. Birthplace Fishing Creek, Md.  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business own home

12. Name Sylvanus Phillips

13. Birthplace Fishing Creek, Md.

14. Maiden name Sarah Rebecca Meekins

15. Birthplace Fishing Creek, Md.

16. Informant Mrs. Ackley Tyler

Address Fishing Creek, Md.

17. Burial Date thereof Dec. 9 1945  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hosier Memorial Cemetery

Location Fishing Creek, Md.

18. Funeral director G. S. Lumber

Address Cambridge, Md.

19. Dec. 8 1945 James W. Meade  
 (Date rec'd by registrar) (month) (day) (year) local Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7 1945 at 5<sup>28</sup> P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Dec. 7 1945, to Dec. 7 1945  
 and that I last saw him alive on Dec. 7 1945

Immediate cause of death Coronary Occlusion DURATION 30 min.

Due to Cardio-Renal Failure

Due to Diase ase with arterio-sclerosis

Other conditions 10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations X Date of op. X

Autopsy results X

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide X Date of X

Where did injury occur? X (City or town) X (County) (State)

Injured at home, farm, industry, public place (whers?) X

Means of Injury X Injured at work? X

23. SIGNATURE James W. Meade M.D. M. D. or other

Address Fishing Creek, Md. Date signed Dec. 8 1945

UNITED STATES DEPARTMENT OF HEALTH

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OCT 15 1945

BUREAU V.S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH: Dorchester  
 County.....  
Cambridge  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 8 yrs. 2 mos  
 Hospital, institution, or street address where death occurred:  
Eastern Shore State Hospital  
 How long in hospital or institution? 8 yrs 2 mos

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
Maryland County Talbot  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

James Edward Elliot3. (b) Social Security Number  
none

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Unknown  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.) October 12 1895  
 8. AGE: Years 50 Months 0 Days 4 If less than one day  
 .....hrs. ....min.

9. Birthplace Oxford, Talbot Cy., Maryland  
 (Town, county, and state)  
 10. Usual occupation Truckster  
 11. Industry or business  
 FATHER 12. Name Isaac E. Elliott  
 13. Birthplace Mardela Wicomico Md.  
 MOTHER 14. Maiden name Augusta Goslin  
 15. Birthplace East New Market, Dorchester Cy Md.

16. Informant Hospital Records  
 Address Cambridge, Maryland  
 17. Burial Date thereof Oct. 19 1945  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Mardella Springs  
Mardella Springs  
 Location J. Beech Clark  
 18. Funeral director Eastern, Md.  
 Address  
 19. 10/19 45 N. H. Harris  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 16 1945 at 11 A M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
June 1 1943 to October 16 1945  
 and that I last saw him alive on October 16 1945  
 Immediate cause of death Coronary Thrombosis  
 DURATION 23  
 Due to.....  
 Due to.....  
 Other conditions General Paresis 10 y  
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....  
 Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?  
 23. SIGNATURE James E. Harris M. D. or other  
 Address Cambridge, Md. Date signed 10/16/45

RECEIVED  
OCT 22 1948  
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

## CERTIFICATE OF DEATH



Reg. Dist. No. 100426

1. PLACE OF DEATH: Cambridge  
 County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? at 4 years  
 Hospital, institution, or street address where death occurred:  
 .....  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State... Maryland County... Prince  
 City or town... Donkey  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 6 Vermont Ave  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME  
Erinos Ellott

3. (b) Social Security Number

4. Sex Male 5. Color or race Black 6. (a) Single, married, widowed, or divorced Widow

6. (b) Name of husband or wife dad

6. (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) March 1 1889

8. AGE: Years 86 Months 7 Days — If less than one day  
 .....hrs. ....min.

9. Birthplace Coard town  
 (Town, county, and state)

10. Usual occupation father

11. Industry or business

12. Name Washington Ellott

13. Birthplace md

14. Maiden name Margaret Ellott

15. Birthplace md

16. Informant Hattie M. Williams

Address Cambridge

17. Coard town Date thereof Oct 4 1945  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Coard town

Location

18. Funeral director Joseph H. Bays

Address Cambridge md

19. 10-1- 45 John MacFarlane md  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 1 19 45, at 10:00 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 12 19 44, to Oct 1 19 45

and that I last saw him alive on September 27 19 45

Immediate cause of death

Coronary thrombosis

Pulmonary edema

Due to Ch. Myocard inf.

Due to

Other conditions Hypertension

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Conroy M. St. Clair MD

M. D. or other

Address Prin Hides St. Date signed 10-2-45

RECEIVED

OCT 8 1945

BUREAU V.B.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlee St., Baltimore 85A

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

## 1. PLACE OF DEATH:

County.....Dorchester  
 City or town.....Cambridge  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....4 yrs. 4 mos.  
 Hospital, institution, or street address where death occurred:  
 Eastern Shore State Hospital  
 How long in hospital or institution?.....4 yrs. 4 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State.....Maryland.....County.....Kent  
 City or town.....Chesterstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

James A. Estes

## 3. (b) Social Security Number

none

4. Sex.....Male  
 5. Color or race.....White  
 6.(a) Single, married, widowed, or divorced.....single  
 6.(b) Name of husband or wife.....  
 6.(c) If alive, give age.....years  
 7. Birth date of deceased (mo., day, yr.).....October 12 1870  
 8. AGE: Years.....74 Months.....11 Days.....30 If less than one day.....hrs. ....min.

9. Birthplace.....Chesterstown, Kent Co Md.  
 (Town, county, and state)

10. Usual occupation.....Carpenter

## 11. Industry or business

FATHER 12. Name.....Charles Albert Estes  
 13. Birthplace.....Elkton Cecil Co. Md.  
 MOTHER 14. Maiden name.....Elizabeth Frazier  
 15. Birthplace.....Chesterstown, Kent Co. Md.

16. Informant.....Hospital Records  
 Address.....Cambridge, Md.

17. Burial.....Date thereof.....Oct 14, 1945  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....6 hosts cam  
 Location.....6 hosts cam

18. Funeral director.....J. Willis Wells  
 Address.....Chesterstown, Md.

19. 10-12-45 John M. [Signature]  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....October 11.....1945.....at 1 a.....M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 June 11 1945 to Oct. 11 1945  
 and that I last saw him alive on October 10 1945

Immediate cause of death.....Bronchopneumonia.....DURATION.....1 day

Due to.....

Due to.....

Other conditions.....General and Cerebral Art- unknown  
 eriosclerosis- Hemiplegia  
 (Include pregnancy within 3 months of death) 6 yrs.

Major findings of operations.....Date of op.....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....Date of.....

Where did injury occur?.....(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....injured at work?

23. SIGNATURE.....M. D. or other

Address.....Cambridge, Md.....Date signed.....10/11/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 15 1945

BUREAU V.S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (41)

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

## 1. PLACE OF DEATH:

County DorchesterCity or town Cambridge  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 months, 21 days

Hospital, institution, or street address where death occurred:

Eastern Shore State HospitalHow long in hospital or institution? 10 months, 21 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarolineCity or town Ridgely  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION) ✓

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Margaret Gardner

## 3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Harry Gardner6.(c) If alive, give age Unk. years7. Birth date of deceased (mo., day, yr.) September 14, 18838. AGE: Years 62 Months 1 Days 11 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Delaware  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own Home12. Name Unknown13. Birthplace Unknown14. Maiden name Margaret Howell15. Birthplace Unknown18. Informant Hospital recordsAddress E.S.S.H., Cambridge, Maryland17. (Burial, cremation, or removal. Which?) Burial Date thereof Oct. 28, 1946  
(month) (day) (year)Cemetery or crematory St. PainesLocallon Ridgely Md.18. Funeral director Raymond B. RayensAddress Leesburg Md19. 10-25 John Mace Jr Registrar  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 25 1945 at 5:50 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 4 1944 to October 25 1945and that I last saw her alive on October 25 1945Immediate cause of death Cerebral Hemorrhage DURATION 2 daysDue to Arteriosclerosis, Hypertension and Chronic Myocarditis and Myocardial Degeneration UnknownOther conditions Diabetes Psychosis with Cerebral Arterio-sclerosis Unknown  
(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Grace M. Branscombe M.D. or other \_\_\_\_\_  
Address E.S.S.H., Cambridge, Md. Date signed 10/25/45

REC'D

OCT 26 1945

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10053

Reg. Dist. No. 116

## 1. PLACE OF DEATH:

County Dorchester  
 City or town Cambridge  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 mos. 1 ds  
 Hospital, institution, or street address where death occurred:  
Easton Shore State Hospital  
 How long in hospital or institution? 5 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Dorchester  
 City or town Rural near Cambridge  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

James T. Hoffner

## 3. (b) Social Security Number

none

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Mary E. Little  
 6. (c) If alive, give age unknown years  
 7. Birth date of deceased (mo., day, yr.) April 10 1875  
 8. AGE: 70 years 6 months 3 days If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Philadelphia, Penn.  
 (Town, county, and state)  
 10. Usual occupation Salesman  
 11. Industry or business \_\_\_\_\_

12. Name Henry Hoffner  
 13. Birthplace Pennsylvania  
 14. Maiden name Sutton  
 15. Birthplace Unknown

16. Informant Hospital Records  
 Address Cambridge, Md.

17. BURIAL Date thereof OCT. 11, 1945  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Hillside Cemetery  
 Location Hillside, Pa.

18. Funeral director LeCompte's Funeral Ser.  
 Address Cambridge, Md.

19. 10-11-45 Registrar John M. ...  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 9 19 45 at 3.40p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
May 8 19 45, to October 9 19 45  
 and that I last saw him alive on October 9 19 45

Immediate cause of death Hypertensive Cardiovascular Disease DURATION unkno  
 \_\_\_\_\_

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions Psychosis with Cerebral Arteriosclerosis- 3yrs.  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Charles ... M. D. or other \_\_\_\_\_  
 Address Cambridge, Md. Date signed Oct 9, 45

RECEIVED  
OCT 15 1945  
BUREAU V. &

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 10052 110

## 1. PLACE OF DEATH:

County Dorchester  
 City or town Hurlock - Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
Boltown  
 How long in hospital or institution? -

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester  
 City or town Hurlock - Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Boltown  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war -

## 3. (a) FULL NAME

Lillie A. Hudson

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Widowed

8.(b) Name of husband or wife Albert Hudson

7. Birth date of deceased (mo., day, yr.) September 15, 1871 8.(c) If alive, give age - years

8. AGE: Years 74 Months 1 Days 4 If less than one day - hrs. - min.

9. Birthplace Dorchester County, Maryland  
 (Town, county, and state)

10. Usual occupation Housework11. Industry or business Home

FATHER 12. Name Wesley Nichols  
 13. Birthplace Dorchester County, Maryland

MOTHER 14. Maternal name Lizzie Jones  
 15. Birthplace Dorchester County, Maryland

16. Informant Walter Hudson  
 Address Hurlock, Maryland, R.F.D.

17. Burial Date thereof October 22, 1945  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Washington CemeteryLocation Near Hurlock, Maryland18. Funeral director J. J. Frampton and SonAddress Federalburg, Maryland

19. Oct 22 1945 Chas W Hastings  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 19 1845, at 7 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1944 19- to Oct. 18 1845  
 and that I last saw him alive on 19

Immediate cause of death Cerebral hemorrhage DURATION 2 days

Due to General arteriosclerosis 10 yrs +

Due to -

Other conditions Smoking

Fractured Hip (Include pregnancy within 3 months of death) due to accidental fall, about six months duration

Major findings of operations - Date of op. Oct. 2

Autopsy results -  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of death about six months ago

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) At home

Means of injury Accidental fall Injured at work? -

23. SIGNATURE William E. Harrison MD M. D. or other

Address Hurlock Md. Date signed 10/20/45

RECEIVED TO THE BUREAU OF THE STATE DEPARTMENT OF HEALTH

STATE OF NEW YORK

RECEIVED  
NOV 3 1945  
BUREAU V.S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (130)

## CERTIFICATE OF DEATH

10054

Reg. Dist. No. 116

## 1. PLACE OF DEATH:

County... DorchesterCity or town... Cambridge  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... DorchesterCity or town... Cambridge  
(If outside city or town limits, write RURAL and give nearest town)Street No. 407 Penn St  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Sarah E Jones

## 3. (b) Social Security Number

4. Sex

female

5. Color or race

colored

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Robert Jones

7. Birth date of

deceased (mo., day, yr.)

July 5 18918. (c) If alive, give age 51 years

8. AGE:

Years

Months

Days

If less than one day

5-432

hrs.

min.

9. Birthplace

Dorchester Dorchester Co Md  
(Town, county, and state)

10. Usual occupation

domestic

11. Industry or business

FATHER

12. Name

Amos Camper

13. Birthplace

Maryland

MOTHER

14. Maiden name

Lizzie Pender

15. Birthplace

Maryland

16. Informant

Elizabeth William

Address

407 Penn St Cambridge Md

17.

(Burial, cremation, or removal. Which?)

Date thereof

Oct 11 1945  
(month) (day) (year)

Cemetery or crematory

Bethel

Location

Cambridge Md

18. Funeral director

Levin H Baynes

Address

Cambridge Md

19.

(Date rec'd by registrar)

10-10-45 John Macfarlane  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 7 1945, at 9:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

September 10 1945 to October 7 1945and that I last saw him alive on October 7 1945

Immediate cause of death

Uremic ComaDue to Acute Nephritis

Due to

Other conditions

Hypertension

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Carroll M St Clair MD  
M. D. or otherAddress Penn St Cambridge Md Date signed 10-9-45

DURATION

2 days6 wks1.8 m

UNITED STATES DEPARTMENT OF HEALTH

UNITED STATES DEPARTMENT OF HEALTH

RECEIVED

OCT 15 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 116

## 1. PLACE OF DEATH:

County Dorchester  
 City or town Cambridge (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? three months  
 Hospital, institution, or street address where death occurred:  
R.F.D.#1 (Christ Rock)  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Dorchester  
 City or town Cambridge (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. R.F.D.#1 box 34  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Ellen R. Keene

## 3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Earl Keene  
 6.(c) If alive, give age 43 years  
 7. Birth date of deceased (mo., day, year) February 29, 1908  
 8. AGE: Years 37 Months 7 Days 20 If less than one day X hrs. min.

9. Birthplace Maryland  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business Home  
 12. Name Harry Keene  
 13. Birthplace Maryland  
 14. Maiden name Aurilla Banks  
 15. Birthplace Maryland

16. Informant Estelle Ennals  
 Address Cambridge, Md. R.F.D.#1

17. Burial (Burial, cremation, or removal, which?) Burial Date thereof 10-25-45  
 (month) (day) (year)  
 Cemetery or crematory Waverly Cemetery  
 Location Green Hill, Md.

18. Funeral director Leaves H. Baysman  
 Address Cambridge, Md.

19. 10-22- 19 15 John Mandy  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 19, 1945 19 11-30P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from X 19 X to X 19 X  
 and that I last saw h. X alive on X 19 X

Immediate cause of death Pulmonary Haemorrhage  
 DURATION X

Due to Pulmonary Tuberculosis 6 years

Due to at Henriton from 1939 until July 7, 1945

Other conditions X  
 (Include pregnancy within 3 months of death)

Major findings of operations X  
 Date of op. X

Autopsy results X  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide X Date of X  
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) X  
 Means of injury X Injured at work?

23. SIGNATURE Dr. H. Shriver, Dep. Med. Exam.  
 M. D. or other X  
 Address Cambridge, Md. Date signed Oct. 20/45

RECEIVED

OCT 24 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

116

## 1. PLACE OF DEATH:

County Dorchester  
 City or town Cambridge  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life time  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester  
 City or town Cambridge  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 222 E. St  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex female 5. Color or race colored 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife

B. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 29 1896

8. AGE: Years 49 Months 5 Days 6 If less than one day  
 hrs. min.

9. Birthplace Bucktown Dor Co Md  
 (Town, county, and state)

10. Usual occupation domestic

11. Industry or business

12. Name Cyrus Long  
 13. Birthplace Cambridge Md  
 14. Maiden name Sarah Pinket  
 15. Birthplace Church Creek Md

16. Informant Thelma Simpson  
 Address 600 N St Cambridge Md

17. burial Date thereof Oct 10 1945  
 (Burial, cremation or removal. Which?) (month) (day) (year)

Cemetery or crematory CambridgeLocation Cambridge18. Funeral director James BayneAddress Cambridge Md

19. 10-10-45 Registrar John Macfarlane  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 5 1945 at 2:20 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 12 1944 to October 5 1945  
 and that I last saw him alive on October 5 1945

Immediate cause of death Cerebral Hemorrhage

DURATION

3 min

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Carol M. H. Chan M. D. or other

Address 222 E St Date signed 10-9-45

RECEIVED

CERTIFICATE OF DEATH

RECEIVED

OCT 15 1945

BUREAU V.S.



VS A15 T

MARGIN RESERVED FOR BINDING

Shriver

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:  
County Dorchester  
City or town Cambridge  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 5 Years  
Hospital, institution, or street address where death occurred:  
Cambridge Maryland Hospital  
How long in hospital or institution? 3 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Dorchester  
City or town Cambridge  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Washington St.  
(If rural, give LOCATION)  
2. (a) If veteran, name war \_\_\_\_\_

3. (a) FULL NAME  
Colonoa D. Moore

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Eliza J. Moore

7. Birth date of deceased (mo., day, yr.) Feb. 4, 1876. 6. (c) If alive, give age 63 years

8. AGE: Years 69 Months 8 Days 16 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Madison, Dor. Co., Maryland.  
(Town, county, and state)

10. Usual occupation Cobler

11. Industry or business Shoe Repair

12. Name W. Gladstone Moore

13. Birthplace Madison, Md.

14. Maiden name Nancy Hart

15. Birthplace Maryland.

16. Informant Mrs. Lottie J. Moore

Address Secretary, Md.

17. Burial Date thereof Oct. 22, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Dorchester Memorial Park

Location Cambridge, Maryland.

18. Funeral director LeCompte's Funeral Service

Address Cambridge, Maryland.

19. 10-22- 45 John Moore Registrar  
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 20 1945 at 11-20 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

\_\_\_\_\_ 1945 to Oct 20 1945

and that I last saw him alive on Oct 20 1945

Immediate cause of death \_\_\_\_\_ DURATION

Disease of Coronary Arteries 2 yr

Due to Chronic Myocarditis 2-3 yr

Due to Cardiac Renal Vascular 45 yr

Other conditions Enlarged Prostate 2-3 yr

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Joe. K. Shriver M.D.

Address Cambridge, Md. Date signed Oct 22/45

RECEIVED

OCT 24 1945

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10058

## CERTIFICATE OF DEATH

★ Reg. Dist. No. 116

<b>1. PLACE OF DEATH:</b> County..... <u>Dorchester</u> City or town..... <u>Cambridge</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <u>several years</u> Hospital, institution, or street address where death occurred: <u>13 Schoolhouse Lane</u> How long in hospital or institution?..... <u>X</u>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State..... <u>Maryland</u> County..... <u>Dorchester</u> City or town..... <u>Cambridge</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... <u>13 Schoolhouse Lane</u> (If rural, give LOCATION) 2.(a) If veteran, name war.....			
<b>3. (a) FULL NAME</b> <u>Anna Marie Perry</u>				<b>3. (b) Social Security Number</b>			
<b>4. Sex</b> <u>Female</u>		<b>5. Color or race</b> <u>Colored</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>Widowed</u>		<b>MEDICAL CERTIFICATION</b>	
<b>B. (b) Name of husband or wife</b> ..... <u>Charles F. Perry</u> B. (c) If alive, give age..... years				<b>20. DATE OF DEATH</b> ..... <u>October 18</u> ..... <u>1945</u> , at <u>Noon</u> <u>M</u>			
<b>7. Birth date of deceased (mo., day, yr.)</b> ..... <u>November 23, 1892</u>				<b>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from</b> <u>X</u> .....19..... to..... <u>X</u> .....19..... and that I last saw h..... <u>X</u> ..... alive on..... <u>X</u> .....19.....			
<b>8. AGE:</b> Years..... <u>52</u> Months..... <u>10</u> Days..... <u>25</u> If less than one day..... <u>X</u> ..... hrs. .... <u>X</u> ..... min.		<b>Immediate cause of death</b> <u>Chronic Myocarditis</u>		<b>DURATION</b> <u>1 year</u>		<b>Due to</b> ..... <u>Cardio-Renal-Vascular Syndrome</u> <b>Due to</b> ..... <b>Other conditions</b> ..... <u>X</u>	
<b>9. Birthplace</b> ..... <u>Maryland</u> (Town, county, and state)				(Include pregnancy within 8 months of death)			
<b>10. Usual occupation</b> ..... <u>Housewife</u> <u>Home</u>				<b>Major findings of operations</b> ..... Date of op. ....			
<b>11. Industry or business</b> .....				<b>Autopsy results</b> ..... <b>PHYSICIAN: Please underline the cause to which death should be charged statistically.</b>			
<b>FATHER</b> 12. Name..... <u>Charles H. Banks</u> 13. Birthplace..... <u>Md.</u>		<b>MOTHER</b> 14. Maiden name..... <u>Eliza Warfield</u> 15. Birthplace..... <u>Md.</u>		<b>22. VIOLENCE: If death was due to external causes, fill in the following:</b> Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town)..... (County)..... (State)..... Injured at home, farm, industry, public place (where?)..... Means of injury..... Injured at work?.....			
<b>16. Informant</b> ..... <u>Harold F. Perry</u> Address..... <u>446 High St. Cambridge, Md.</u>				<b>22. VIOLENCE: If death was due to external causes, fill in the following:</b> Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town)..... (County)..... (State)..... Injured at home, farm, industry, public place (where?)..... Means of injury..... Injured at work?.....			
<b>17. Burial</b> ..... Date thereof..... <u>10-22-45</u> (Burial, cremation, or removal. Which?)..... (month) (day) (year) Cemetery or crematory..... <u>Cemetery</u> Location..... <u>Cambridge Md.</u> <u>Lewis N. Bayne</u> <b>18. Funeral director</b> ..... Address..... <u>Cambridge Md.</u> <u>John H. Hays</u> <b>19.</b> ..... <u>10-22-1945</u> ..... <u>10-22-45</u> (Date rec'd by registrar)..... Registrar.....				Address..... <u>Cambridge, Md.</u> Date signed..... <u>Oct. 18/45</u>			

RECEIVED  
OCT 24 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

## CERTIFICATE OF DEATH

★ Reg. Dist. No. 10059 115

## 1. PLACE OF DEATH:

County Dorchester  
 City or town Toddville  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
Home

How long in hospital or institution? .....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester  
 City or town Toddville  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Rural  
 (If rural, give LOCATION)

2. (a) If veteran, name war X

## 3. (a) FULL NAME

BESSIE MAY PHILLIPS.

## 3. (b) Social Security Number

X

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Married

6. (b) Name of husband or wife Goldsborough Phillips.7. Birth date of deceased (mo., day, yr.) 8. (c) If alive, give age 53 years

1/7/1896

8. AGE: Years Months Days If less than one day  
49 8 25 ..... hrs. .... min.

9. Birthplace Toddville, Md.  
 (Town, county, and state)

10. Usual occupation Domestic11. Industry or business Home12. Name Milbourn Todd13. Birthplace Md.14. Maiden name Lola A. Jones.15. Birthplace Md.16. Informant Goldsborough Phillips.Address Toddville, Md.,

17. Burial Date thereof 10/4/1945  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Zion Church CemeteryLocation Toddville, Md.,18. Funeral director LeCompte Funeral Service.Address Cambridge, Md.,

19. Oct 4 45 Wilson & Pitchell  
 (Date rec'd by registrar) (month) (day) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 2, 19 45, 5.33 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Oct. 1 19 45 to Oct. 1 19 45  
 and that I last saw her alive on Oct. 1 19 45

Immediate cause of death Apoplexy  
 DURATION 12 hours

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work?

23. SIGNATURE P. H. Turner M. D. or otherAddress Cambridge, Md. Date signed 10/2/45

RECEIVED  
NOV 3 1945  
BUREAU V.M.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 10660/16

## 1. PLACE OF DEATH:

County... Dorchester  
 City or town... Cambridge, Md.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... DorchesterCity or town... Cambridge

(If outside city or town limits write RURAL and give nearest town)

Street No. 2 Choptank Ave.

(If rural give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Emanuel Pugh

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

Edith Sinclair

## 7. Birth date of deceased (mo., day, yr.)

Sept 26 1869

## 6. (c) If alive, give age... years

## 8. AGE:

Years

Months

Days

If less than one day

76020

hrs.

min.

## 9. Birthplace

Illinois  
(Town, county, and state)

## 10. Usual occupation

Cabinet Maker

## 11. Industry or business

Woodworker

## FATHER

## 12. Name

Peter Pugh

## 13. Birthplace

Illinois

## MOTHER

## 14. Maiden name

Anna - unknown

## 15. Birthplace

Illinois

## 16. Informant

Major Gordon S. Pugh.

## Address

Cambridge, Md.

## 17.

(Burial, cremation, or removal. Which?)

## Date thereof

10-19-1945  
(month) (day) (year)

## Cemetery or crematory

St. Carmel Hill - Col.

## Location

East Crowdetts Dec.

## 18. Funeral director

Kenneth R. Thomas

## Address

Cambridge, Md.

## 19.

10/17/45  
(Date rec'd by registrar)John M. [unclear]  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16 19 45 at 4:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 8th 19 45 to Oct 16th 19 45and that I last saw him alive on Oct 14 19 45

## Immediate cause of death

Carcinoma of Liver

## DURATION

1 wkt.

Due to

Due to

Other conditions

Uremia6 days

(Include pregnancy within 8 months of death)

## Major findings of operations

None

Date of op.

## Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did it occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

Eldridge H. Wolfford

M. D. or other

Address

Cambridge, Md.Date signed 10-16-45



RECEIVED  
OCT 18 1945  
BUREAU V.E.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157-2

## CERTIFICATE OF DEATH

Reg. Dist. No. 111

### 1. PLACE OF DEATH:

County Dorchester  
City or town East New Market - Rural  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 days  
Hospital, institution, or street address where death occurred:  
Hickelburg Road Rt #1  
How long in hospital or institution? —

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Dorchester  
City or town East New Market - Rural  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Hickelburg Road Rt #1  
(If rural, give LOCATION)  
2.(a) If veteran, name war —

### 3. (a) FULL NAME

Samuel Jesse Sampson

### 3. (b) Social Security Number

4. Sex male 5. Color or race col 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife —

7. Birth date of deceased (mo., day, yr.) Oct 13 - 1945 8. (c) If alive, give age — years

8. AGE: Years X Months X Days 4 If less than one day — hrs. — min.

9. Birthplace Dorchester Co. Md  
(Town, county, and state)

10. Usual occupation none

11. Industry or business X

12. Name Benjamin F. Sampson

13. Birthplace Maryland

14. Maiden name Edna Mae Jackson

15. Birthplace Maryland

16. Informant Benj. F. Sampson

Address East New Market - Md

17. Burial, cremation, or removal, which? Burial Date thereof Oct 18 1945  
(month) (day) (year)

Cemetery or crematory Cemetery

Location Flournoy Farm

19. Funeral director W. B. Yellowknife

Address East New Market

19. Oct 18 19 45 Elizabeth C. Smith  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17 19 45 at 4:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 — to — 19 —

and that I last saw him — alive on — 19 —

Immediate cause of death — DURATION —

Congenital Malformation

Due to of heart 4 days

Due to —

Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE Dr. K. Shriver, Dep. Med. Exam.

M. D. or other —

Address Cambridge - Md Date signed Oct 18/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

RECEIVED

RECEIVED

OCT 24 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

★ Reg. Dist. No. 116

10662

## 1. PLACE OF DEATH

County Sauces  
 City or town Cambridge  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? approximately 11 hours  
 Hospital, institution, or street address where death occurred:  
Cambridge Maryland Hospital  
 How long in hospital or institution? approximately 11 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Sauces  
 City or town Cambridge  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 442 Willis St.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Lola WRIGHT

## 3. (b) Social Security Number

Shores 214-07-8428

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow  
 6.(b) Name of husband or wife GEORGE C. SHORES  
 (Deceased 11/10/1939) 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) DEC. 6, 1895.  
 8. AGE: Years 49 (49) Months 10 Days 13 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Richmond Virginia  
 (Town, county, and state)  
 10. Usual occupation Phillips Packing Co.  
 11. Industry or business Canned Goods  
 12. Name Altona Wright  
 13. Birthplace Richmond, Va.  
 14. Maiden name Not known  
 15. Birthplace " "

16. Informant Mabelle Shores  
 Address 442 Willis St.

17. Burial Date thereof Oct. 23, 1945  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory GREENLAWN Cemetery  
 Location Cambridge, Maryland

18. Funeral director LeCompte's Funeral Service  
 Address Cambridge, Maryland

19. 10-22 19 45 John Mawdsen  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 19 19 45 at 9:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 18<sup>th</sup> 19 45 to October 19<sup>th</sup> 19 45  
 and that I last saw her alive on October 19<sup>th</sup> 19 45

Immediate cause of death

Carcinoma of Stomach

Due to Carcinoma of Stomach

Due to Metastasis to Liver

Other conditions Profound anemia

(Include pregnancy within 8 months of death)

Major findings of operations None

Date of op. \_\_\_\_\_

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE

Eldridge Hyblford  
 Address Cambridge Md Date signed 10-19-45

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED  
OCT 24 1945  
BUREAU V.S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:  
County Dorchester  
City or town Cambridge  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 63 Years  
Hospital, institution, or street address where death occurred:  
210 Oakley St.  
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Dorchester  
City or town Cambridge  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 210 Oakley St.  
(If rural, give LOCATION)  
2.(a) If veteran, name war -

3. (a) FULL NAME  
John Bell Spedden

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Maude Cook

7. Birth date of deceased (mo., day, yr.) Oct. 4, 1860 6.(c) If alive, give age 78 years

8. AGE: Years 85 Months - Days 17 If less than one day - hrs. - min.

9. Birthplace Neck District, Dor. Co., Md.  
(Town, county, and state)

10. Usual occupation Retired Merchant

11. Industry or business

12. Name Rufus Spedden

13. Birthplace Maryland

14. Maiden name Elizabeth Marshall

15. Birthplace Maryland.

16. Informant Mrs. Hubert Applegarth

Address Fishing Creek, Maryland.

17. Burial Date thereof Oct. 23, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cambridge Cemetery

Location Cambridge, Maryland.

18. Funeral director LeCompte's Funeral Service

Address Cambridge, Maryland.

19. 10-23- 19 45 John Macfarland  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21 19 41 at 12:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 19 41 to Feb 21 19 41

and that I last saw him alive on Oct 19 19 41

Immediate cause of death Coronary thrombosis

Due to Coronary Thrombosis

Due to Coronary Thrombosis

Other conditions -

(Include pregnancy within 3 months of death)

Major findings of operations -

Date of op. -

Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? - (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -

Means of injury - Injured at work? -

23. SIGNATURE John Macfarland M. D. or other

Address Cambridge, Md Date signed 10-23-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Meekins

10063

RECEIVED  
OCT 24 1945

BUREAU V.K.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10064

Reg. Dist. No. 116

## 1. PLACE OF DEATH:

County DorchesterCity or town Cambridge  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 Mths.

Hospital, institution, or street address where death occurred:

Glasgow St.How long in hospital or institution? -

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Cambridge  
(If outside city or town limits, write RURAL and give nearest town)Street No. Glasgow St.

(If rural, give LOCATION)

2. (a) If veteran, name war -

## 3. (a) FULL NAME

Fedora Stauffer Tripp

## 3. (b) Social Security Number

-

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Julian Tripp6. (c) If alive, give age 69 years

## 7. Birth date of

deceased (mo., day, yr.)

Jan. 23, 1883.

## 8. AGE:

Years

62

Months

9

Days

2

if less than one day

hrs.

min.

## 9. Birthplace

Newark, New Jersey

(Town, county, and state)

## 10. Usual occupation

Domestic

## 11. Industry or business

Home

## FATHER

## 12. Name

J. B. Thompson

## 13. Birthplace

New Jersey

## MOTHER

## 14. Maiden name

Sarah Louise Stauffer

## 15. Birthplace

Pennsylvania

## 16. Informant

Mr. Julian TrippAddress Glasgow St., Cambridge, Md.

## 17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof Oct. 27, 1945

(month) (day) (year)

Cemetery or crematory Spring Hill CemeteryLocation Easton, Maryland.

## 18. Funeral director

LeCompte's Funeral Service

Address

Cambridge, Maryland.

## 19.

Oct. 27, 1945

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24 19 45 at 7: P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 26 19 45 to Oct. 24 19 45  
and that I last saw her alive on October 24 19 45

Immediate cause of death

Hemi-plegia, left

DURATION

11 hours

Due to

arteriosclerosis  
generalized.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Eldridge Hedger  
Cambridge, Md. Date signed 10-26-45

RECEIVED  
OCT 30 1945  
BUREAU T.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 19102

## CERTIFICATE OF DEATH

Reg. Dist. No. 10065 116

## 1. PLACE OF DEATH:

County... Dorchester  
 City or town... Cambridge  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 33 years  
 Hospital, institution, or street address where death occurred:  
314 Pine Street (home)  
 How long in hospital or institution? — — —

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Dorchester  
 City or town... Cambridge  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... 314 Pine Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war... none

## 3. (a) FULL NAME

Mary VA. Waters

## 3. (b) Social Security Number

none

4. Sex female 5. Color or race colored 6. (a) Single, married, widowed, or divorced widow  
 8. AGE: Years 77 Months 9 Days 6 It less than one day — — — hrs. — — — min.  
 9. Birthplace... Hurlock, Maryland  
 (Town, county, and state)  
 10. Usual occupation... House work  
 11. Industry or business own home  
 12. Name... Nathan Jackson  
 13. Birthplace Maryland  
 14. Maiden name... Joanna Daniels  
 15. Birthplace Maryland

7. Birth date of deceased (mo., day, yr.) February 17, 1868  
 6. (c) If alive, give age — — years  
 8. (b) Name of husband or wife... Elisha Waters  
 6. (c) If alive, give age — — years

18. Informant... Houston Waters  
 Address Cambridge, Maryland  
 17. Burial... Date thereof... 10-28-45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory... Petersburg Cemetery  
 Location... Hurlock, Maryland  
 18. Funeral director... Lewis H. Bayneum  
 Address Cambridge, Maryland  
 19. 10-25-45 Dr. John Massie Jr.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... October 23 1945, at 2:00 A.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 26 1945, to October 23 1945  
 and that I last saw him or her alive on October 20 1945

Immediate cause of death... Uremia DURATION 4-5 days  
 Due to... arteriosclerotic cardio-vascular renal disease 1 year+  
 Due to... arteriosclerosis generalized 1 year+  
 Other conditions... Blindness, Bilateral due to cataracts 1 year+  
 (Include pregnancy within 3 months of death)

Major findings of operations... none Date of op. — — —  
 Autopsy results... none  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide... none Date of — — —  
 Where did injury occur? — — — (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) — — —  
 Means of injury — — — Injured at work? — — —

23. SIGNATURE... Eldridge H. Jeff. M.D. M. D. or other  
 Address... Cambridge, Maryland Date signed 10-23-45

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OCT 26 1945  
BUREAU V F

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 48-2

## CERTIFICATE OF DEATH

★ Reg. Dist. No. 116

1. PLACE OF DEATH:  
County Dorchester  
City or town Cambridge  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 20 Yrs.  
Hospital, institution, or street address where death occurred:  
6 Ross St.  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Dorchester  
City or town Cambridge  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 6 Ross St.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME  
Lula May Wingate

3. (b) Social Security Number  
214-07-7675

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Otto Wingate

7. Birth date of deceased (mo., day, yr.) May 26, 1892. 6.(c) If alive, give age years

8. AGE: Years 53 Months 4 Days 15 If less than one day hrs. min.

9. Birthplace Dorchester County, Maryland.  
(Town, county, and state)

10. Usual occupation Phillips Packing Co.

11. Industry or business Canned Foods Packer

12. Name Henry Willey

13. Birthplace Maryland.

14. Maiden name Ada Bramble

15. Birthplace Maryland.

16. Informant Mrs. Wm. W. Jones

Address Cambridge, Maryland.

17. Burial Date thereof Oct. 14, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Dorchester Memorial Park

Location Cambridge, Maryland.

18. Funeral director LeCompte's Funeral Service

Address Cambridge, Maryland.

19. 10-19-45 (Date rec'd by registrar)

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11, 1945 at 10:45 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 19<sup>th</sup> 1945 to October 11 1945  
and that I last saw her alive on October 11 1945

Immediate cause of death Carcinoma of Cervix

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Eldridge Hubbard

M. D. or other

Address Cambridge, Md. Date signed 10-15-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Wolff

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OCT 22 1945  
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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 89a

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

<b>1. PLACE OF DEATH:</b> County... <u>Dorchester</u> City or town... <u>Cambridge</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>2 Years</u> Hospital, institution, or street address where death occurred: <u>1 Harrington Ave.</u> How long in hospital or institution? <u>-</u>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State... <u>Maryland</u> County... <u>Dorchester</u> City or town... <u>Cambridge</u> (If outside city or town limits, write RURAL and give nearest town) Street No... <u>1 Harrington Ave.</u> (If rural, give LOCATION) 2. (a) If veteran, name war... <u>-</u>			
<b>3. (a) FULL NAME</b> <u>Anna Kaiser Wiser</u>				<b>3. (b) Social Security Number</b> <u>-</u>			
<b>4. Sex</b> <u>Female</u>		<b>5. Color or race</b> <u>White</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>Widowed</u>			
<b>6. (b) Name of husband or wife</b> <u>William R. Wiser</u> (Deceased 1943)				<b>6. (c) If alive, give age</b> ... years			
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>Dec. 26, 1878.</u>							
<b>8. AGE:</b> Years <u>65</u>		Months <u>9</u>		Days <u>14</u>		If less than one day hrs. min.	
<b>9. Birthplace</b> ... <u>Baltimore, Maryland.</u> (Town, county, and state)							
<b>10. Usual occupation</b> ... <u>Domestic</u>							
<b>11. Industry or business</b> ... <u>Home</u>							
<b>FATHER</b>		<b>12. Name</b> ... <u>George Kaiser</u>					
<b>MOTHER</b>		<b>13. Birthplace</b> ... <u>Maryland.</u>					
		<b>14. Maiden name</b> ... <u>Anna Kaiser</u>					
		<b>15. Birthplace</b> ... <u>Maryland.</u>					
<b>16. Informant</b> ... <u>Mr. Wm. R. Wiser</u> Address... <u>1273 63rd. St., Baltimore, Md.</u>							
<b>17. Burial</b> ... <u>Oct. 13, 1945</u> (Burial, cremation, or removal. Which?) (month) (day) (year) Cemetery or crematory... <u>Greenlawn Cemetery</u> Location... <u>Cambridge, Maryland.</u>							
<b>18. Funeral director</b> ... <u>LeCompte's Funeral Service</u> Address... <u>Cambridge, Maryland.</u>							
<b>19.</b> <u>10-13-</u> <u>15-</u> <u>John Macer Jr. M.D.</u> (Date rec'd by registrar) Registrar							
<b>MEDICAL CERTIFICATION</b> <b>20. DATE OF DEATH</b> ... <u>Oct. 10, 1945</u> at <u>4: P.</u> M. <b>21. I CERTIFY</b> that death occurred on the date above stated; that I attended deceased from <u>Oct 6</u> 19 <u>45</u> to <u>Oct 10</u> 19 <u>45</u> and that I last saw him alive on <u>Oct 10</u> 19 <u>45</u> Immediate cause of death... <u>Cerebral Hemorrhage</u> Due to... <u>arteriosclerosis</u> Due to... <u>hypertension</u> Other conditions... (Include pregnancy within 8 months of death) Major findings of operations... Autopsy results... PHYSICIAN: Please underline the cause to which death should be charged statistically.							
<b>22. VIOLENCE:</b> If death was due to external causes, fill in the following: Accident, suicide, or homicide... Date of... Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury Injured at work? <b>23. SIGNATURE</b> ... <u>John Macer Jr. M.D.</u> M. D. or other Address... Date signed <u>10-12-45</u>							

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OCT 18 1945  
BUREAU OF